


1. Initial Step in Creating a Small Business Health Options (SHOP) Account

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Done

Basic Company Information * REQUIRED FIELD

ENTER COMPANY NAME: * ?


Eg: ABC Corporation

DO YOU HAVE AN EMPLOYER IDENTIFICATION NUMBER (EIN)? * ?

☐ YES





☐ NO

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FIND US ON:    

2. Entering Personal and Account Information

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Create an Account



Creating a user account is free and helps you save work.



* REQUIRED FIELD

Personal Information


Smith Electronics - EIN: 23-3242342

FIRST NAME *  M.I.  LAST NAME * 



DATE OF BIRTH *  SSN * 

NOTIFICATION PREFERENCE  NOTIFICATION LANGUAGE 



Account Information

USER NAME * 

Must be 5-15 letters or numbers.


PASSWORD *  RE-ENTER PASSWORD * 


Must be 6-15 characters with at least one number, one upper case letter and one lower case letter.

EMAIL ADDRESS *  RE-ENTER EMAIL * 


Security Questions

You will need to answer these questions if you forget your sign-in information.


QUESTION 1 * 

ANSWER TO QUESTION 1 * 


1-15 numbers or characters


QUESTION 2 * 

1-15 numbers or characters

ANSWER TO QUESTION 2 * 

Must be 5-15 letters or numbers.

QUESTION 3 * 

ANSWER TO QUESTION 3 * 


1-15 numbers or characters

Attestations


☐ I Attest That

1. My company is in the state of Washington or one of my employees resides in the state of Washington.
2. My company is providing insurance to all my full-time employees.
3. My company has 50 or fewer full-time equivalent employees.

User Acceptance Agreement





☐ Yes, I accept the User Acceptance Agreement, which specifies how many information will be kept confidential and secure. **Health Insurance Exchange User Acceptance Agreement.** Click here to read the agreement, which tells you more about how we will keep your personal information private and secure. 

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3. Entering Detailed Employer Information

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Detailed Company Information

*** REQUIRED FIELD**

Smith Electronics

Primary Business Contact Information

Fill the following fields with the company information.

ADDRESS LINE 1 * [?](#)
Eg. 1234 Main Street

ADDRESS LINE 2 * [?](#)
Eg. Suite 1000

CITY * [?](#)
Eg. Seattle

STATE * [?](#)
Washington

ZIP * [?](#)
Eg. 98501

PHONE NUMBER * [?](#)
Eg. 123-45-6789

FAX NUMBER * [?](#)
Eg. 123-45-6789

COUNTRY * [?](#)
US

☒ Check if you have a different mailing address. [?](#)

Mailing Address

ADDRESS LINE 1 * [?](#)
Eg. 1234 Main Street

ADDRESS LINE 2 * [?](#)
Eg. Suite 1000

CITY * [?](#)
Eg. Seattle

STATE * [?](#)
Washington

ZIP * [?](#)
Eg. 98501

PHONE NUMBER * [?](#)
Eg. 123-45-6789

FAX NUMBER * [?](#)
Eg. 123-45-6789

COUNTRY * [?](#)
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4. Utilizing a Broker to Manage the SHOP Account

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Get An Insurance Broker's Help * REQUIRED FIELD

You have the option of using a licensed insurance broker or agent. We will notify the broker or agent you choose. They can then access your account and help with the application.

SEARCH BY: ? ENTER SEARCH CRITERIA: * ?

Last Name ▼

Smith

Find Brokers

Search Results

	Name	Address	Phone	Email
<input checked="" type="radio"/>	Tom J Smith	123 Main Street Olympia WA, 98501	360-321-2234	tsmith@gmail.com
<input type="radio"/>	Judy L Smith	33 W. 3rd Street Olympia WA, 98501	360-331-2233	j.smith@aol.com

Exchange Account

DO YOU HAVE AN EXCHANGE ACCOUNT? ?

☐ YES

☒ NO

Contact Details

Please provide contact details, the selected broker will reach out to you shortly.

FIRST NAME: * ? LAST NAME: * ? EMAIL: * ?

Eg: John

Eg: Smith


Eg: jsmith@mail.com

PHONE NUMBER: * ? BEST METHOD TO CONTACT: * ?

Eg: 123-456-7890

- Select an Option - ▼





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5. Entering Information in the Employee Roster

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About Your Employees

* REQUIRED FIELD

Choose a method to add your employees:*

☒ ENTER MY EMPLOYEES MANUALLY

☐ UPLOAD MY EMPLOYEES USING A SPREADSHEET

I want to provide coverage for:*

☒ EMPLOYEES AND THEIR DEPENDENTS

☐ EMPLOYEES ONLY

Employees Added

Last Name	First Name	SSN	Date of Birth	Edit	Remove
Markson	John	***.***.8932	10/31/2010		
Johnson	Mark	***.***.1234	01/08/1945		

Manual Entry

Please provide us with employee information by manually entering the fields below. Click on the Add Employees button to add an employee to the roster.

Add Employee

FIRST NAME *
Eg. John

M.I.
Eg. J

LAST NAME *
Eg. Smith

DATE OF BIRTH *
Eg. 01/20/2012

ZIP *
Eg. 98501

SSN *
Eg. 123-45-6789

EMAIL ADDRESS *
jdoe@mail.com

PARTICIPATION STATUS:
- Select an Option -

FULL-TIME STATUS: *
☐ FULL TIME
☐ PART TIME

TOBACCO USE: *
☐ YES
☐ NO

Dependent 1

RELATIONSHIP: *
- Select One -

DATE OF BIRTH *
Eg. 01/20/2012

TOBACCO USE: *
☐ YES ☐ NO

Remove Dependent

Dependent 2

RELATIONSHIP: *
- Select One -

DATE OF BIRTH *
Eg. 01/20/2012

TOBACCO USE: *
☐ YES ☐ NO

Add Another Dependent

Add Employee

Assign Administrator

I want to allow one of my employees to manage this account.

CHOOSE EMPLOYEE *
Select an Employee

[Back](#) [Submit Employee Roster](#)


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6. Design the Plan Approach

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Design Your Plan * REQUIRED FIELD

Description of Design your plan, text to be defined. Description of Design your plan, text to be defined.

Single Plan Option

This text needs to say something about the Single Plan option and how it is the best option because it allows an employer to select just one plan and know how much it is going to cost him over the long run.

☐ ONE PLAN (ONE CHOICE/SIMPLE)

This needs to be text about how the single plan is the best and the following are the benefits that you get by choosing the single plan:

✓ Benefit number 1

✓ Benefit number 2

✓ Benefit number 3

✓ Benefit number 4

✓ Benefit number 5

✓ Benefit number 6

Employee Choice Option

This text needs to say something about the Employee Choice Option and how much it is going to cost him over the long run.

☐ BRONZE (LOW COST/LOW BENEFITS)

This needs to be text around what it means to be a bronze plan and what the benefits are for these plans.

☐ SILVER (MEDIUM COST/MEDIUM BENEFITS)

This needs to be text around what it means to be a silver plan and what the benefits are for these plans.


☐ GOLD (HIGH COST/GOOD BENEFITS)

This needs to be text around what it means to be a gold plan and what the benefits are for these plans.

☐ PLATINUM (HIGHEST COST/BEST BENEFITS)

This needs to be text around what it means to be a platinum plan and what the benefits are for these plans.




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7. Selecting a One-Plan Approach

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Compare Plans

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	Humana: Value 100/7500 Remove from Comparison Choose This Plan	SOLO Outlook Active 10 Remove from Comparison Choose This Plan	Basic PPO 70/30 Plan Remove from Comparison Choose This Plan
Total Plan Premium	\$ 11,000	\$ 12,000	\$ 13,000
Total Employer Contribution	\$ 6,000	\$ 7,000	\$ 8,000
Health Care Provider	Out-of-network	Out-of-network	In-network
Standard Deductible	\$7,500	\$7,500	\$7,500
Other Deductibles	Prescription Deductible Applies: \$1,000 Individual. Applies to Levels 2,3,4	Prescription Deductible Applies: \$1,000 Individual. Applies to Levels 2,3,4	Prescription Deductible Applies: \$1,000 Individual. Applies to Levels 2,3,4
Out-of-Pocket limit	Deductible	Deductible	Deductible
Co-Pays	Primary Office: No charge after deductible Prescriptions: • Generic drugs: \$20 • Branded drugs: \$20 • Non-Formulary drugs: No charge after deductible • Mail order charges for drugs: Not available Emergency Room: \$150	Primary Office: No charge after deductible Prescriptions: • Generic drugs: \$20 • Branded drugs: \$20 • Non-Formulary drugs: No charge after deductible • Mail order charges for drugs: Not available Emergency Room: \$150	Primary Office: No charge after deductible Prescriptions: • Generic drugs: \$20 • Branded drugs: \$20 • Non-Formulary drugs: No charge after deductible • Mail order charges for drugs: Not available Emergency Room: \$150
Quality Rating	★★★★☆	★★★★☆	★★★★☆
Consumer Rating	★★★★★	★★★★☆	★★★★☆
Provider Network	Yes Humana/Choice Care Network PPO	Yes Humana/Choice Care Network PPO	Yes Humana/Choice Care Network PPO
Out-of-Network Costs	View Out-Of-Network Costs	View Out-Of-Network Costs	View Out-Of-Network Costs
Referral Requirement	No	No	No
Services Not Covered	No	No	No
Plan Level	Silver	Silver	Silver
Plan Type	PPO	PPO	PPO
Specialist Co-Pay	\$100 Co-Pay (Waived if admitted), then No Charge after deductible	\$100 Co-Pay (Waived if admitted), then No Charge after deductible	\$100 Co-Pay (Waived if admitted), then No Charge after deductible
Coinurance	No Charge after deductible	30% Coinsurance after deductible	15% Coinsurance after deductible
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Health Savings Account(HSA) Eligible	No	No	Yes
Well Baby Care	No charge	No charge	No charge
Periodic Health Exam	\$100 Copay (waived if admitted), then no charge after deductible	Covered after deductible, \$150 copay per visit (waived if admitted) at Category 1 coinsurance	\$150 Copay
Periodic OB-GYN Exam	No Charge after deductible	30% Coinsurance after deductible	15% Coinsurance after deductible
Outpatient Lab/X-ray	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Surgery	No charge after deductible	No charge after deductible	No charge after deductible
Hospitalization	\$100 Co-Pay (Waived if admitted), then No Charge after deductible	\$100 Co-Pay (Waived if admitted), then No Charge after deductible	\$100 Co-Pay (Waived if admitted), then No Charge after deductible
Pre & PostNatal Office Visit	No charge after deductible	No charge after deductible	No charge after deductible
Labor & Delivery Hospital Stay	No charge after deductible	No charge after deductible	No charge after deductible
Chiropractic Coverage	No charge after deductible	No charge after deductible	No charge after deductible
Mental Health Coverage	No Charge after deductible	30% Coinsurance after deductible	Not Covered
AM Best Rating	B-+	A-	A-
Plan Brochure(PDF)	View Brochure [PDF]	View Brochure [PDF]	View Brochure [PDF]
Primary Care Physician (PCP) Required	Yes	No	No

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8. Selecting a Metal Level of Plans

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My Search

ZIP: [Update](#)
98501

Eligible Employees: 3


Eligible Dependents: [Update](#)
1


Plan Selection: [Update](#)
Single Plan


Provider Search


Doctor/Hospital: [Remove](#)
Dr. Stephanie Carter


Customize My Search

Total Estimated Premium 
☐ \$5,000 - \$9,000
☒ \$9,000 - \$13,000
☐ \$13,000 - \$17,000
☐ \$17,000 - \$21,000
☐ \$21,000 - \$25,000

Total Employer Cont. 
☐ \$2,500 - \$4,500
☐ \$4,500 - \$6,500
☐ \$6,500 - \$8,500
☐ \$8,500 - \$10,500
☐ \$10,500 - \$12,500

Deductible 
☐ \$1,000 - \$2,800
☐ \$2,800 - \$4,600
☐ \$4,600 - \$6,400
☐ \$6,400 - \$8,200
☐ \$8,200 - \$10,000

Insurance Company 
☐ Rocky Mountain Health Plans
☐ Cigna
☐ Celtic Ins. Co.
☐ LifeWise Health Plan of Washington

Metal Level 
☐ Bronze
☐ Silver
☐ Gold
☐ Platinum

[Update](#)


Contributions

Please set your contribution percentage for employees' premiums.

Please set your contribution percentage for dependents' premiums.



[Update](#)

[View Comparisons \(2\)](#) 18 Plans Found [Previous](#) [Show: 5 Per Page](#) [Next](#) [Sort By: Price](#)


 **PLAN: BRONZE**
Evergreen PPO
[More information on this plan](#)

PLAN SUMMARY

PRIMARY CARE CO-PAY \$400	EMERGENCY ROOM 30% CO-INSURANCE AFTER DEDUCTIBLE	DEDUCTIBLE \$10,000	OUT-OF-POCKET MAX \$15,000
-------------------------------------	--	-------------------------------	--------------------------------------



Dr. Stephanie Carter - In Network
Consumer Rating:  Quality Rating: 

[Remove From Compare](#) [Select This Plan](#)


 **PLAN: BRONZE**
Evergreen PPO
[More information on this plan](#)

PLAN SUMMARY

PRIMARY CARE CO-PAY \$300	EMERGENCY ROOM 30% CO-INSURANCE AFTER DEDUCTIBLE	DEDUCTIBLE \$10,000	OUT-OF-POCKET MAX \$15,000
-------------------------------------	--	-------------------------------	--------------------------------------



Dr. Stephanie Carter - In Network
Consumer Rating:  Quality Rating: 

[Add to Compare](#) [Select This Plan](#)


 **PLAN: BRONZE**
Evergreen PPO
[More information on this plan](#)

PLAN SUMMARY

PRIMARY CARE CO-PAY \$200	EMERGENCY ROOM 30% CO-INSURANCE AFTER DEDUCTIBLE	DEDUCTIBLE \$10,000	OUT-OF-POCKET MAX \$15,000
-------------------------------------	--	-------------------------------	--------------------------------------



Dr. Stephanie Carter - In Network
Consumer Rating:  Quality Rating: 

[Add to Compare](#) [Select This Plan](#)


 **PLAN: BRONZE**
Evergreen PPO
[More information on this plan](#)

PLAN SUMMARY

PRIMARY CARE CO-PAY \$100	EMERGENCY ROOM 30% CO-INSURANCE AFTER DEDUCTIBLE	DEDUCTIBLE \$10,000	OUT-OF-POCKET MAX \$15,000
-------------------------------------	--	-------------------------------	--------------------------------------



Dr. Stephanie Carter - In Network
Consumer Rating:  Quality Rating: 

[Add to Compare](#) [Select This Plan](#)

 **PLAN: BRONZE**
Evergreen PPO
[More information on this plan](#)

PLAN SUMMARY





PRIMARY CARE CO-PAY \$0	EMERGENCY ROOM 30% CO-INSURANCE AFTER DEDUCTIBLE	DEDUCTIBLE \$10,000	OUT-OF-POCKET MAX \$15,000
-----------------------------------	--	-------------------------------	--------------------------------------

Dr. Stephanie Carter - In Network
Consumer Rating:  Quality Rating: 

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9. Reviewing Monthly Contribution Screen

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Estimated Summary

Review your share of the monthly premium costs for your employees.

Employees	Family Size	Participation Status	Est. Total Employee Cost	Est. Total Employer Cont.	Est. Total Plan Premium
John Doe	2	Elected for Coverage	\$ 500	\$ 250	\$ 250
Tom Smith	3	Elected for Coverage	\$ 700	\$ 350	\$ 350
Steve Thomas	1	Elected for Coverage	\$ 300	\$ 150	\$ 150

Disclaimer: Rates are final at enrollment. Changes to company or employee information can affect your final rates.





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12. Employer Next Steps

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Next Steps


Thank you for using the Washington Health Benefit Exchange. You can print this page for your records. To return to your dashboard, click on the button below.

Employee-specific URL

Please share this link with your employees in order to complete your health plan enrollment. This link will guide your employees to the Health Benefit Exchange to allow them to select the coverage you have selected.

Send This Link to All My Employees





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13. After Employee Selections, Employer Views Application Summary Screen

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Final Summary

General Information

Contribution Defined for Employee:

75%

Contribution Defined for Dependents:

45%

Total number of Employees:

7


Total number of Dependents:





3

Thompson Bakery

Employee Name	Family Size	Elected For Coverage	Plan Selected	Total Premium	Employer Cost	Employee Cost
John Doe	2	Elected for Coverage	Assurant Plan	\$ 400	\$ 300	\$ 100
John Doe	2	Elected for Coverage	Assurant Plan	\$ 400	\$ 300	\$ 100
Jeff McDaniels	4	Elected for Coverage	Assurant Plan	\$ 600	\$ 500	\$ 100
John Doe	2	Waived Coverage				
John Doe	2	Non-Participation				
Total:				\$ 1,400	\$ 1,100	\$ 300

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14. Employer eSignature

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Your Signature * REQUIRED FIELD

I have agreed to submit this application by electronic means By signing this application electronically. I certify under penalty and false swearing that my answers are correct and complete to the best of my knowledge.

I also certify that:

- I understand the questions and statements on this application.
- I understand the penalties for giving false information or breaking the rules.
- I understand that the Exchange may contact other persons or organization.
- I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

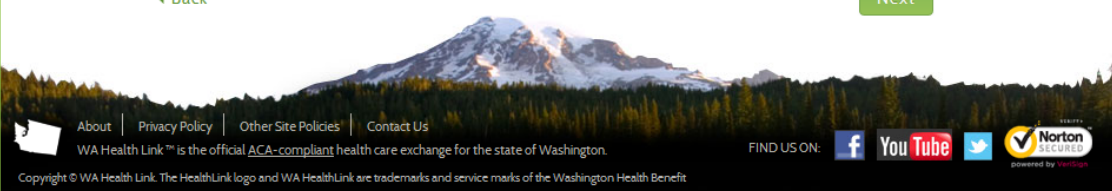
☐ By clicking this box and typing my name below, I am electronically signing my application. * ?

FIRST NAME * ?
Eg. John
JOHN





M.I. ?
M.I.
DOE

LAST NAME * ?
Eg. Smith
DOE

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15. Dashboard to Manage Account

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OPEN ENROLLMENT: OCTOBER 1, 2013 TO MARCH 31, 2014

Account Home | Billing & Payments | Me and My Household | Action Center

Dear Customer Lorem Ipsum Dolor Sit Amet

Duis velit magna, facilisis et viverra at, vulputate in lacus. Suspendisse potenti. Nunc justo arcu, facilisis vitae tempor vitae, ultricies quis orci. Maecenas a lorem ac urna varius consectetur ac ut nulla. Mauris volutpat purus sagittis augue aliquam.

Message Center

Velit magna, facilisis et viverra at, vulputate in lacus ultr...	October 26, 2012
Maecenas a lorem ac urna varius consectetur ac ut nulla...	November 12, 2012
Volutpat purus sagittis augue aliquam ullamcorper...	November 20, 2012

View More ▶

My Plans

Individual Covered	Plan Name	Plan Telephone	Effective Date	Renewal Date	Enrollment Status
John Smith	Assurant Health	800-888-1234	Dec 1, 2014	Dec 1, 2015	Enrolled
Sophie Smith	Assurant Health	800-888-1234	Dec 1, 2014	Dec 1, 2015	Enrolled
Connor Smith	CHIP	800-888-5678	Dec 1, 2014	Dec 1, 2015	Enrolled - Pending Action Needed!

Quick Links


Pay Now

Report a Change in Income or Household




Change Account Settings

Submit Document

Submit or Track Complaints or Appeals




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